

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 27 1957

State File No. **18979**
Registrar's No. **4515**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 4515	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 53 yrs.		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 721 Pestalozzi St.				e. STREET ADDRESS (If rural, give location) 1237 1907 Sidney Street			
3. NAME OF DECEASED (Type or Print) Clarence		a. (First) _____ b. (Middle) (Pete) c. (Last) Loggins		4. DATE OF DEATH (Month) (Day) (Year) May 10 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH March 23, 1904	
9. AGE (in years last birthday) 53 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottler		10b. KIND OF BUSINESS OR INDUSTRY Brewery		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA				13a. FATHER'S NAME John Henry Loggins			
13b. MOTHER'S MAIDEN NAME Kate Hollander				14. NAME OF HUSBAND OR WIFE Irene Weis Loggins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. _____			
17. INFORMANT'S SIGNATURE OR NAME Mrs. Irene Loggins				ADDRESS 1907 Sidney St.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 1 min. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary artery arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION 420.1			
20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____			
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____				21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR? _____				22. I hereby certify that I attended the deceased from May 1957 , to May 10, 1957 , that I last saw the deceased alive on Feb 16, 1957 and that death occurred at 11:55 AM , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Edmund G. Chruska MD				23b. ADDRESS 3701 Grand St.			
23c. DATE SIGNED 5/15/57				24a. BURIAL, CREMATION, REMOVAL (Specify) Removal			
24b. DATE 5-13-57				24c. NAME OF CEMETERY OR CREMATORY Mount Evergreen Cemetery			
24d. LOCATION (City, town, or county) (State) Millstadt, Illinois				25. FUNERAL DIRECTOR'S SIGNATURE BEIDERWIEDEN F.H. INC.			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 13 1957				ADDRESS 1936 St. Louis Ave.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Hours beginning 12:30 or 1
Saturday

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 45

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.